



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

February 12, 2008

Linda Ghramm, Administrator
The Courtyard on Division by Beehive #2
2100 East Sherman Ave
Coeur d' Alene, ID 83814

License #: RC-881

Dear Ms. Ghramm:

On January 8, 2008, a complaint investigation, state licensure survey was conducted at Courtyard on Division by Beehive #2-Silver Valley Beehive Homes, The. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Rachel Corey, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 23, 2008

Linda Ghramm, Administrator
The Courtyard on Division by Beehive #2
2100 East Sherman Ave
Coeur d'Alene, ID 83814

Dear Ms. Ghramm:

On January 8, 2008, a complaint investigation, state licensure survey was conducted at Courtyard on Division by Beehive #2-Silver Valley Beehive Homes. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by February 8, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to be 'J. Simpson', written over a horizontal line.

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R881	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2008
NAME OF PROVIDER OR SUPPLIER COURTYARD ON DIVISION BY BEEHIVE #2-SII			STREET ADDRESS, CITY, STATE, ZIP CODE 208 SOUTH DIVISION PINEHURST, ID 83850		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>Initial Comments</p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the initial survey and complaint investigation conducted at your facility. The surveyors conducting the initial survey and complaint investigation were:</p> <p>Rachel Corey, R.N. Team Coordinator Health Facility Surveyor</p> <p>Debbie Sholley L.S.W. Health Facility Surveyor</p>	R 000			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

93NC11

If continuation sheet 1 of 1



IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

January 23, 2008

Linda Ghramm, Administrator
The Courtyard on Division by Beehive #2
2100 East Sherman Ave
Coeur d'Alene, ID 83814

Dear Ms. Ghramm:

On January 8, 2008, a complaint investigation survey was conducted at Courtyard on Division by Beehive #2-Silver Valley Beehive Homes. The survey was conducted by Rachel Corey, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003291

Allegation #1: The facility did not provide a safe environment for a resident. An identified resident drank finger nail polish.

Findings: Based on interview and record review it was determined the identified resident drank finger nail polish.

The incident report dated October 21, 2007 documented the resident drank finger nail polish while under the supervision of a outside service provider.

Further, the incident report documented the facility notified the resident's physician and the facility's licensed nurse on October 21, 2007 at 11:15 a.m., to get direction on the necessary medical attention. It was documented the facility was to monitor the resident for nausea.

On January 1, 2008 at 10:40 a.m., the house manager confirmed the resident had drank the nail polish. However, she stated the outside service provider was supervising the resident at the time of the incident. The house manager stated the outside service provider admitted she should have watched the resident more closely.

Conclusion #1: Substantiated. However, the facility was not cited as they acted appropriately by notifying the resident's physician and the facility nurse to report the incident and get further direction on the required medical care the resident may have needed.

Allegation #2: An identified resident drank wax out of a lit candle.

Findings #2: Based on observation and interview it could not be determined the resident drank wax out of a lit candle.

On January 7, 2008 through January 1, 2008 there were no candles observed in the facility.

Observation of the identified resident on January 7, 2008 at 3:00 p.m., revealed no evidence of scarring to the face or mouth. Additionally, on January 1, 2008 at 8:15 a.m., the resident was observed to eat at least 50 percent of her fruit, pancakes, and all of her bacon without apparent difficulty.

On January 1, 2008 at 10:45 a.m., the house manager stated an outside service provider notified her that a resident had drank candle wax from a lit candle. She further stated upon her investigation of the alleged incident, no one had observed the incident. The facility nurse assessed the resident and found no evidence of burn marks, redness, or signs of candle wax in the resident's mouth. Additionally, the house manager stated at the time of the alleged incident, the resident exhibited no signs of pain or discomfort.

Conclusion #2: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Rachel Corey, RN, Health Facility Surveyor



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Courtland on Division #2 Pinhurst</i>	Physical Address <i>208 South Division</i>	Phone Number <i>208-682-4818</i>
Administrator <i>Michael Mahun (acting)</i>	City <i>Pinehurst, ID 83850</i>	ZIP Code <i>83850</i>
Survey Team Leader <i>Rachel Corey</i>	Survey Type <i>Complaint/Initial Survey</i>	Survey Date <i>1-8-08</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	225.01a-g	The facility did not have behavior management plans to include a-g items.	1/24/08	
2	225.02b-c	The behavior management tracking form for Resident #3 did not reflect that a least restrictive intervention was utilized before prn medications. Interventions were not followed up 72 hours after implementation of intervention.	1/24/08	
3	305.01	A nursing assessment of each resident's response to medications and therapies was not conducted for 3 of 3 sampled residents.	2/4/08	
4	305.02	PRN medications were not available as ordered (ie standing orders)	2/11/08	
5	305.03	The nurse did not have nursing assessments conducted on 3 of 3 sampled residents regarding their health status.	2/4/08	
6	305.04	The facility nurse did not document recommendations made to the administrator regarding health or medication needs or changes to the NSA.	2/4/08	
7	305.05	The facility R.W. did not document a review and follow-up	2/4/08	

Response Required Date <i>2-8-08</i>	Signature of Facility Representative <i>M. Mahun</i>	Date Signed <i>1/8/08</i>
---	---	------------------------------



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Courtyard on Division #2 Pinehurst</i>	Physical Address <i>208 South Division</i>	Phone Number <i>208-682-4818</i>
Administrator <i>Michaela Michon</i>	City <i>Pinehurst, ID</i>	ZIP Code <i>83850</i>
Survey Team Leader <i>Rachel Corey</i>	Survey Type <i>Complaint, Initial</i>	Survey Date <i>1-8-08</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
7	305.05	on recommendations made to the administrator.	<i>2/4/08</i>	
8	310.01d	During medication pass residents were administered medications rather than assisted with when medications were spooned into a resident's mouth.	<i>2/8/08</i>	
9	320.01	The NSA's for 2 of 3 sampled residents did not describe outside services, the frequency of services and how services were to be delivered. For 3 of 3 sampled residents the NSA did not clearly describe the level of assistance needed for ADL's and individual care needs specific to resident.	<i>2/4/08</i>	
10	350.01	All appropriate reportable incidents for Resident #3 were not reported to Licensing & Survey agency within 24 hours. (ie resident to resident incident)	<i>2/4/08</i>	
11	6030.02	2 of 2 sampled staff did not have specialized Mental illness training	<i>2/4/08</i>	

Response Required Date <i>2-8-08</i>	Signature of Facility Representative <i>M. McKenna</i>	Date Signed <i>1/8/08</i>
---	---	------------------------------